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Part VII Aesthetic Approach of Scalp

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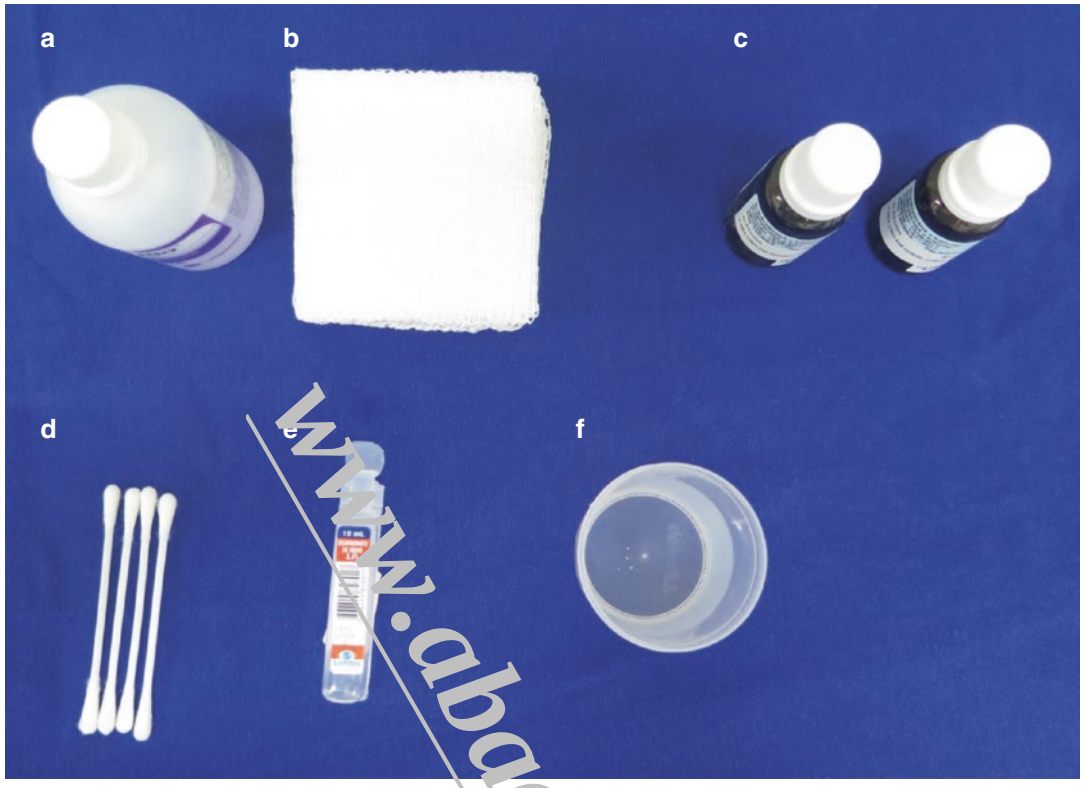

Fig. 15.1 The materials to be used. (**a**) Acetone. (**b**) Ga… (**c**) Fifty to eighty-percent pyruvic acid in hydroalcoholic solution. (**d**) Cotton swabs. (**e**) 8.4% sodium bicarbonate sol…on. (**f**) Water

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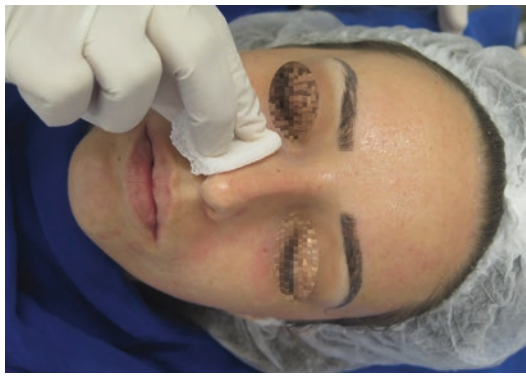

Fig. 15.2 The skin should be cleansed with acetone

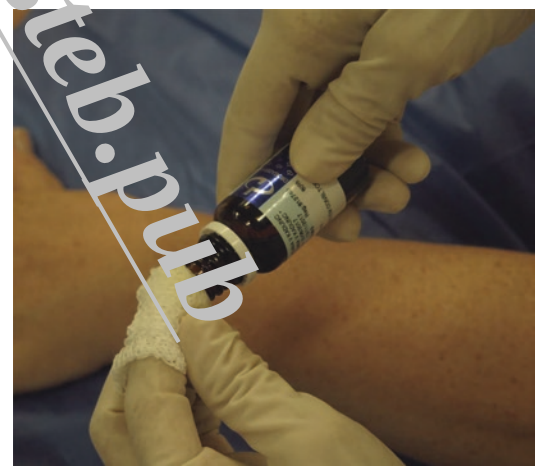

Fig. 15.3 The pyruvic acid should be applied with a gauze

- An informed consent that explains the procedure, complications, and risks should be signed before.
- Standard photography registry is authorized by the patient.
- Start the procedure with a deep facial skin cleansing using a gauze and the degreasing solution, taking off residual cosmetics and skin grease.
- Apply solid petroleum jelly in the mouth angles and other areas we would like to protect.
- Pour trichloroacetic acid in the recipient, and soak the gauze or cotton tip in the acid not letting the acid drain.
- The use of TCA for performing chemical extrafacial peels has been reported mainly in two vehicles: aqueous solution and water-soluble paste.
- Apply a first layer of TCA (15–35%) in a homogeneous way considering the cosmetic units; this can be done in the whole extrafacial or only in the areas to be treated [4] (Figs. 22.2 and 22.3).

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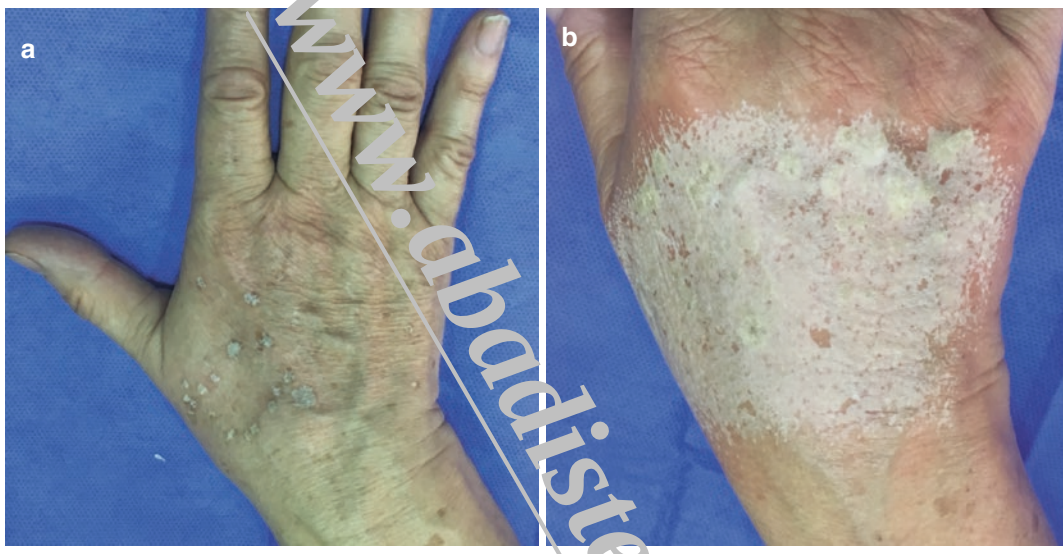

Fig. 22.2 (**a**) Homogeneous application with cotton tip of TCA 35% peeling in keratosis area. (**b**) Homogeneous application with gauzes of TCA 20% peeling in a back of the hand in cosmetic unit

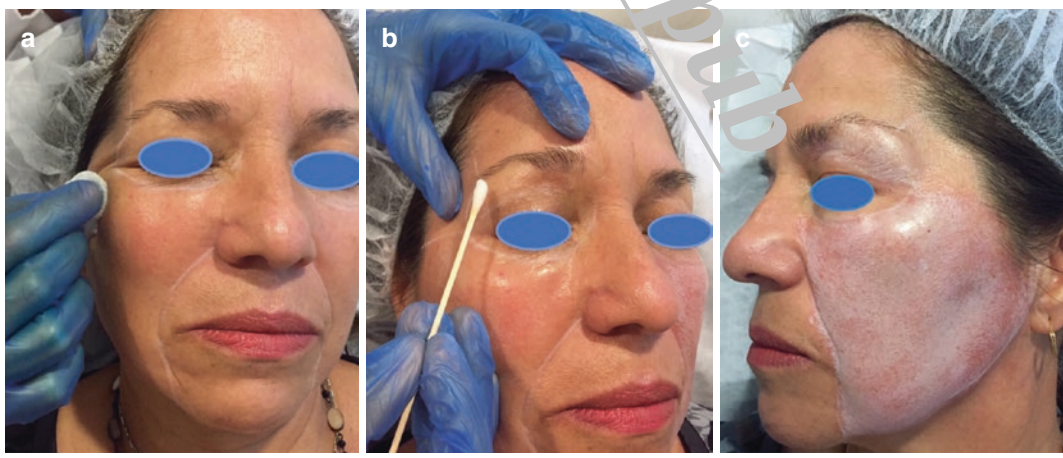

Fig. 22.3 (**a**) Homogeneous application with gauzes of TCA 15% peeling in a cheek cosmetic unit. (**b**) Homogeneous application with cotton tip of TCA 20% peeling in periocular area. (**c**) Homogeneous frosting in cosmetic unit

Mark the area using a pen marker (Fig. 27.2).

The distance between the points is around 1 cm (Fig. 27.2).

- Administer the injection by introducing the needle superficially in the skin until a small papule is seen. Inject 0.5 U of Botox per point [1].
  - It is possible to treat only the affected area, but sometimes it is necessary to balance by treating other areas to avoid an anesthetic result [1, 2]. For example, if you treat all of the frontal area, then it is also necessary to treat the glabella (Fig. 27.3)
- Marking other areas for treatment (Fig. 27.4 and Fig. 27.5)

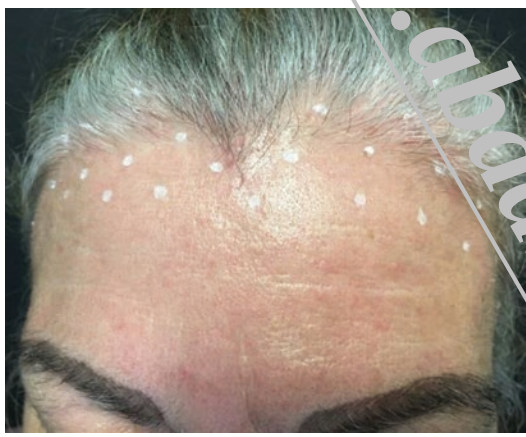

Fig. 27.2 Distance between the frontal area points where botulin toxin will be injected

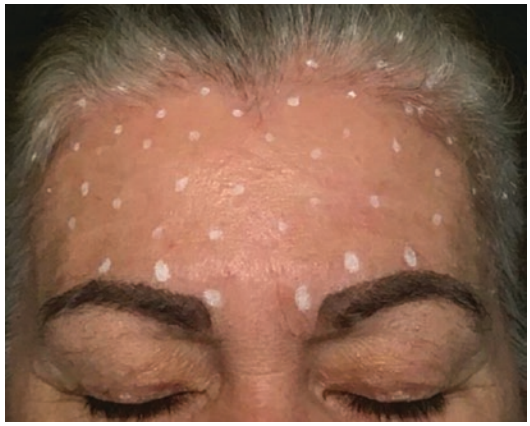

Fig. 27.3 Treating glabella when the entire frontal is being treated for hyperhidrosis

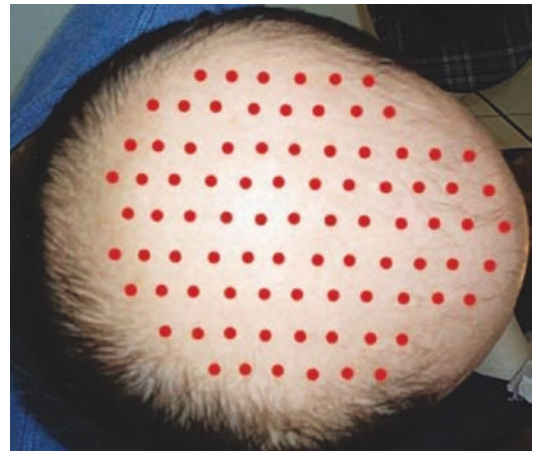

Fig. 27.4 Marking the scalp area to treat hyperhidrosis. (Courtesy: Neves [7]). Source: Copyright authorized by Samantha Neves, Beatriz C. Avè, Ayres 25. Indd 319

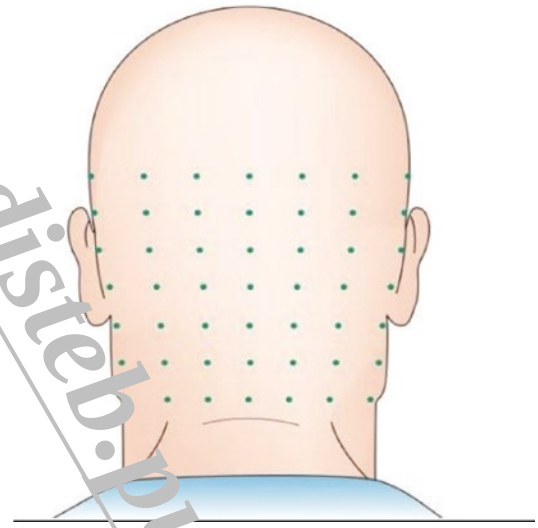

Fig. 27.5 Marking nape area to treat hyperhidrosis. (Courtesy: Neves [7]). Source: Copyright authorized by Samantha Neves, Beatriz C. Avè, Ayres 25. Indd 318

27.3 Clinical Follow-Up

Reduction in sweat will be noticed after 48 h, but sometimes, we have to wait for 2 weeks.

The reduction sometimes is progressive, but in other cases, it stops suddenly [3].

27.4 Before and After (Figs. 27.6, 27.7, 27.8, and 27.9)

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Fig. 33.2 Material for botulinum toxin application

Fig. 33.3 Injection adapter

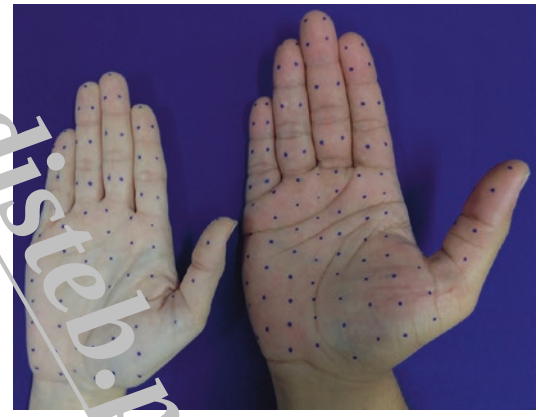

Fig. 33.4 Marking on different sizes of palms

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33.2.2 Product Reconstitution

For 100-U vials (Botox® (Allergan, Irvine,CA; Xeomin® Merz, Germany; Prosigne, Lanzhou, China), 2–4 cc of saline solution.

For 500-U vials (Dysport®, Ipsen, UK), 3.2 mL of saline solution.

33.2.3 Injection Technique

33.2.3.1 Palmar

Dose: 1.5–2.0 BoNT-A U/site. Average of 100 U/hand

Larger doses per site may induce larger diffusion. The physician's assistant holds ice cubes involved in gauze on the palmar or plantar skin for 10–30 s before injection (Fig. 33.5a–c) [2, 3].

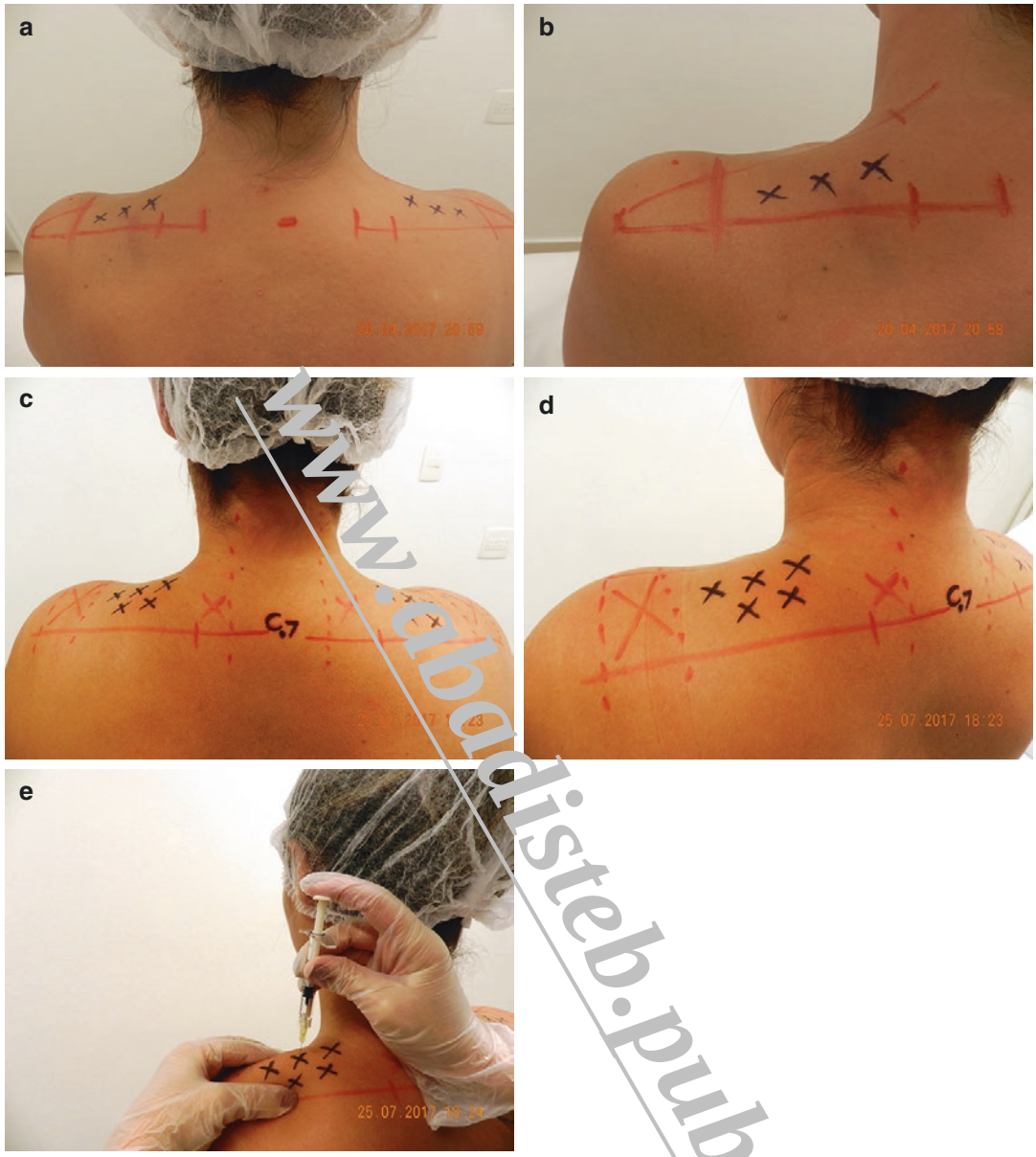

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Fig. 38.2 (**a**, **b**) Patient who needs three points in each side. (**c**) Patient who needs 5 points in each side. (**d**) Patient who needs 5 points in each side. (**e**) Patient who needs 5 points in each side

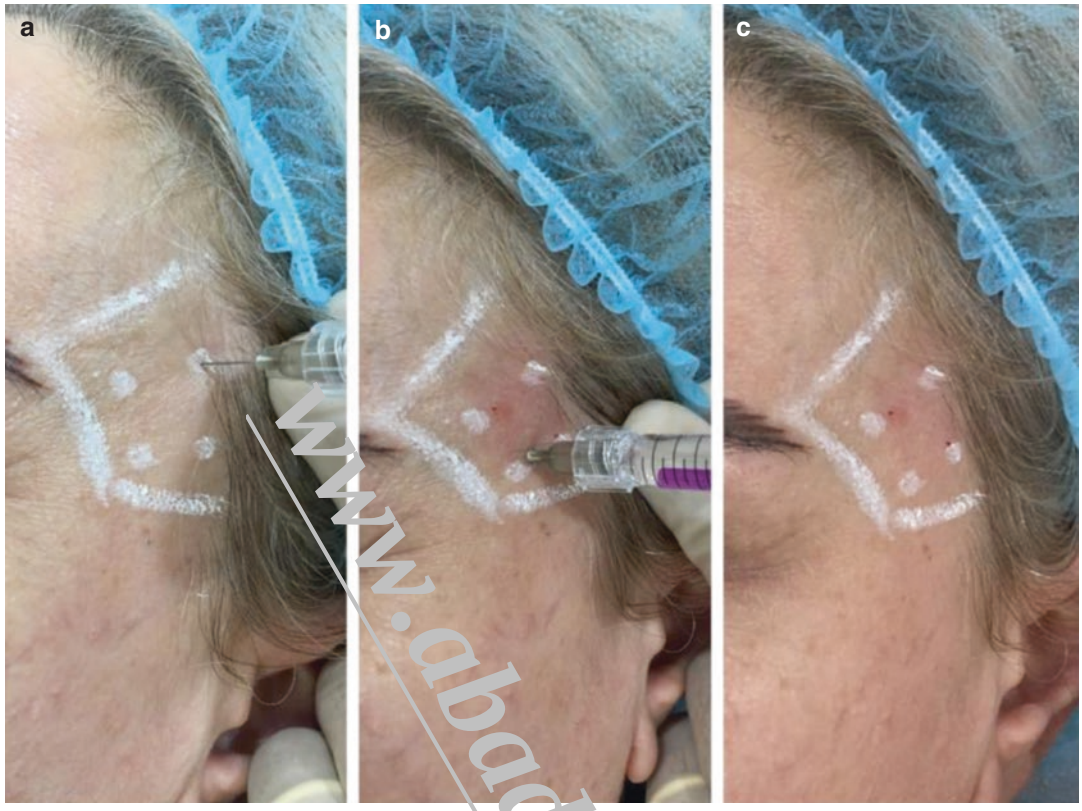

Fig. 51.3 (**a**) Deeper to the temporalis muscle technique; (**b**) Deep bolus injection to the supra-periosteal plane. Commonly 3–5 boluses are enough, depending on the volume loss and area size. (**c**) Immediate result

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  - Using a bolus technique, the filler is placed through several boluses, between 3 and 6, and then massaged with enough pressure to assure an even distribution.
  - This does not require local or topical anesthesia.
- Cons (Fig. 51.3):
  - This technique usually needs more filler quantity (more volume) for being able to lift the temporal muscle from the periosteum, to which it is strongly attached.
  - It can cause more discomfort to the patient due to the pressure involved in the injection and the muscle stretch.
  - It can lead to an increased possibility for bruising and suffusion/hematoma (intramuscular injection).
  - There is increased risk for filler migration and displacement due to the increase in pressure, muscular action, and continuity to the pterygomaxillar and infratemporal fossa (Fig. 51.4).

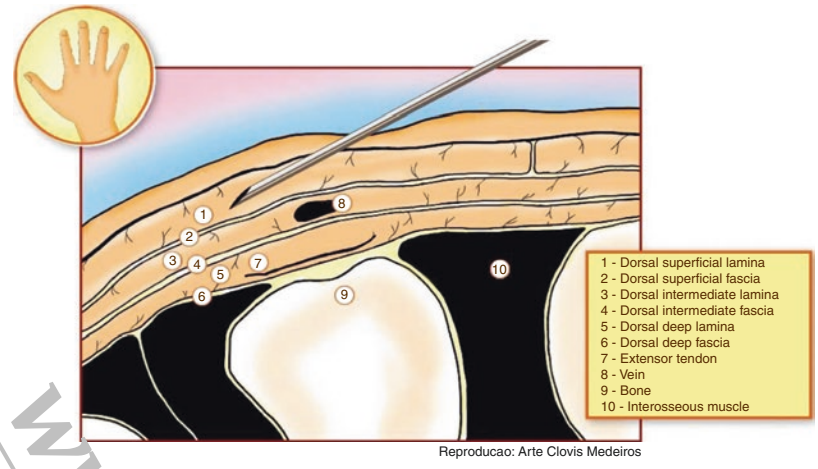

Fig. 69.5 Topographic anatomy of the dorsum of the hand. The needle is introduced in the dorsal superficial lamina

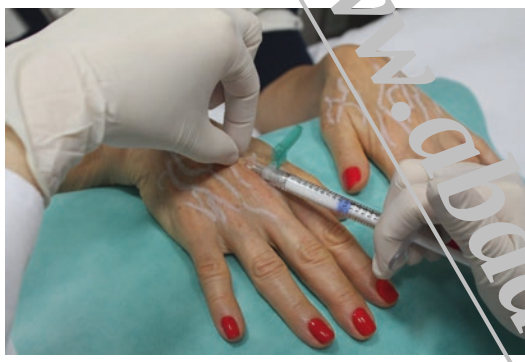

Fig. 69.6 One hand makes the tent while the other makes the injection

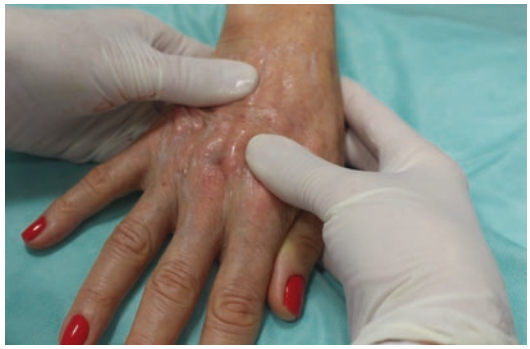

Fig. 69.7 Massage to spread the injected product

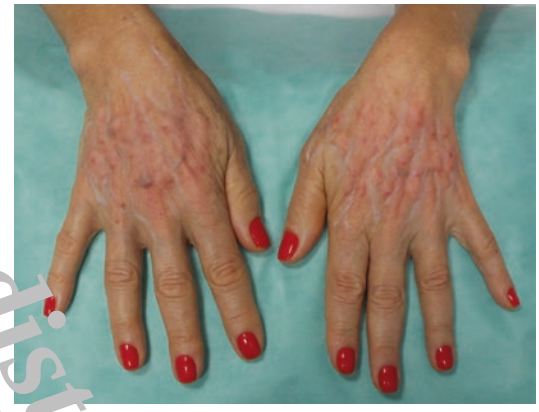

Fig. 69.8 Nodular aspect and hematoma after the injection of C[illegible], prior to the massage

69.3 Follow-Up

- The patient should be advised on the initial nodular aspect of the procedure and on the possibility of hematoma and edema (Fig. 69.8).
- Local massage 2 times a day for approximately 7 days can be performed by the patient in order to better spread the product and undo the nodules.
- The patient may be instructed to sit on the hands after the procedure. This will help to spread the product and avoid hematomas.
- Application of ice compresses for approximately 24 h and sun avoidance are recommended after the procedure.
- Oral corticosteroids may be administered for a short period of time in patients with severe edema.

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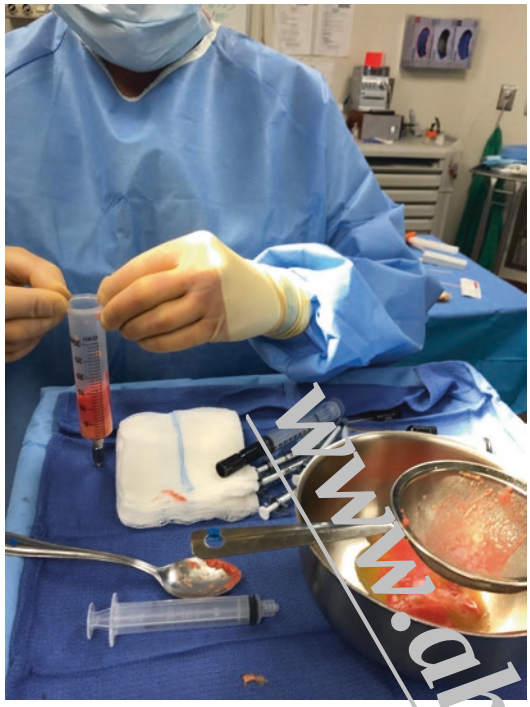

Fig. 98.3 This picture shows the microfat already harvested in the 10 cc syringes. Note the strainer that is used to collect and separate the fat from the infiltration solution before its use. A spoon is commonly used to strain the fat and transfer it back into the 10 cc syringe before injection

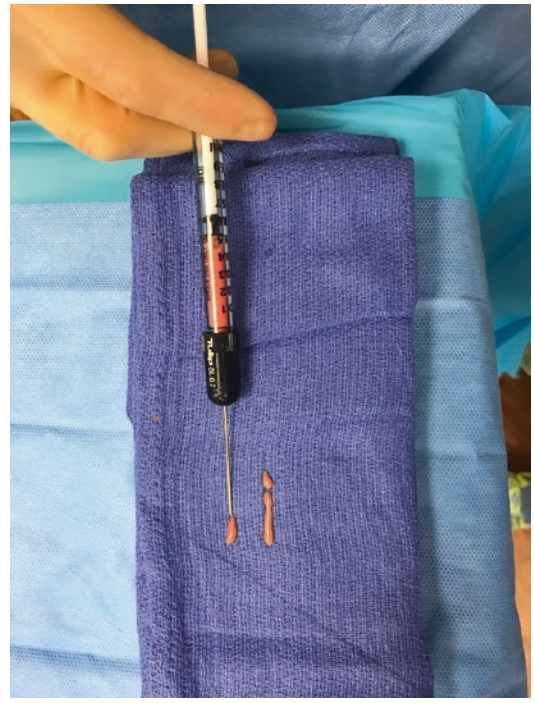

Fig. 98.4 This picture shows the soft and smooth consistency of the nanofat already transferred into the 1 cc syringes and ready to be used for facial volumization through a 0.7 mm blunt cannula

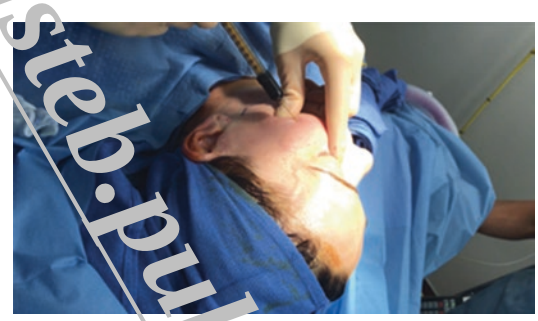

Fig. 98.5 This picture shows an intraoperative image of microfat transfer into midface for facial volumization

98.3 Clinical Follow-Up

- Moderate swelling and bruising are expected and can last for 2–4 weeks, depending on how much fat was used and the selected placement site.
- Patients are seen in clinic on POD1 and then in 1 week, 1 month, 6 months and a year for follow-up visits.
- The average fat uptake is about 50% of the total initial volume [2].
- Expected partial fat reabsorption occurs during the first 4–6 months.
- The fat that remains in the grafted areas at 6 months after the procedure is permanent.

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